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CHILD/ADOLESCENT HISTORY QUESTIONNAIRE

CONFIDENTIAL

The purpose of the questionnaire is to obtain background data concerning your daughter. By completing this confidential form as fully as possible, you are assisting our staff with this evaluation and helping to ensure all information is clarified. If you wish to add any additional comments, please do so on the last sheet.

Date: _____ Daughter's Name: _____Date of Birth: _____Age____
Address:_____ City _____ State _____ Zip___
Child's Pediatrician: _____ Phone #: _____
Person completing this form: _____ Relationship to Child: _____

FAMILY INFORMATION:
Father's Name: _____ Age: _____ Education: _____
Employment: _____ Phone Number: _____
Mother's Name: _____ Age: _____ Education: _____
Employment: _____ Phone Number: _____
Daughter's parents are currently: Married _____ Divorced _____ Separated _____
Other: _____
Is your daughter adopted? Yes _____ No _____ List other siblings (names and ages) in the home:

_____

REFERRAL INFORMATION: Who referred you to our practice?
Name: _____ Phone #: _____

PRIMARY CONCERNS:
Please describe the problem(s) or concerns for which you are seeking help at this time:

_____

_____
When did the problem(s) first appear or begin?

_____
Whom else have you consulted about your daughter's problem(s) (i.e. pediatrician, psychiatrist, psychologist, social worker, therapist, counselor)?

_____
What procedures have you tried on your own?

_____
Have there been any changes in your daughter's eating, sleeping, or mood/behavior recently?
Does your daughter have any health conditions we should be aware of?:

Has your daughter ever received any of the following diagnoses? Check box to the left if "YES."

	Anxiety Disorder		Developmental Delay
	Attention Deficit/Hyperactivity Disorder		Disruptive Behavior Disorder
	Autism Spectrum Disorder		Feeding Disorder
	Cognitive Disability (MR)		Learning Disability
	Conduct Disorder		Seizure Disorder
	Depression		Tic Disorder
	Other: _____		Eating Disorders (i.e. purging, restricting, binging, laxative use)

Diagnosed by? _____
Date of diagnosis: _____
Is your daughter currently in therapy? _____
Has your daughter seen a therapist in the past? ____

Other/Comments:

_____

Does your daughter demonstrate any of the following behaviors? Check box to the left if "YES."

	Impulsivity, lack of self-control		Suicidal attempts or ideation
	Hyperactivity		Substance abuse (i.e. drinking or drug use)
	Attention problems		Lying
	Inappropriate sexual behavior		Self-injurious behaviors (i.e. cutting)
	Aggressive behavior (i.e. hitting, kicking, biting)		Motor tics
	Verbal abuse (i.e. swearing)		Verbal tics
	Noncompliance at home		Running away/Elopement
	Noncompliance at school		Stealing
	Overreacting to situations (i.e. cries easily, short temper)		

Other/Comments:

_____

Please describe your daughter's temperament. Check box to the left if "YES."

	Shy/Timid		Stubborn
	Affectionate		Temperamental/Moody
	Dare Devil/Bold		Fearful
	Cautious		Overactive
	Underactive		Happy
	Easy to Manage		Curious
	Aggressive		Slow to warm up

Other/Comments:

_____

Do you have any concerns about your daughter's social interactions?

_____
_____

MEDICATION HISTORY:
Has your daughter ever taken psychiatric medications? Yes _____ No _____
If Yes: Name of Medication: _____ Prescribed By: _____
For treatment of: _____
Is your child currently taking this medication?: _____

SCHOOL INFORMATION:
Name of current school: _____
Grade: _____

ADDITIONAL INFORMATION:
Describe your daughter's strengths:

_____
_____
What does your daughter enjoy doing the most?

_____
Describe your daughter's technology use:

_____
_____
Do you have any concerns with her screen time?

_____
_____
Is there anything else you feel we should know about your daughter?

_____
_____
_____
_____
_____

Signature: _____ Date: _____